

Running head: 'THEY DAREN'T TELL PEOPLE'

## 'They daren't tell people': Therapists' experiences of working with clients who report anomalous experiences

An anomalous experience (AE)<sup>1</sup> is defined as 'an uncommon experience (e.g., synesthesia) or one that, although it may be experienced by a significant number of persons (e.g., psi experiences), is believed to deviate from ordinary experience or from the usually accepted explanations of reality according to Western mainstream science' (Cardeña, Lynn, & Krippner, 2014 p. 4). Some of the AEs that have been reported in the literature include extrasensory perception (ESP), near-death experiences (NDEs), out-of-body experiences (OBEs), contact with the deceased, and synchronicity experiences (SEs) (see Appendix). A substantial proportion of the general population claim to have had AEs, with a number of surveys reporting prevalence rates of over 50% (see Dein, 2012).

Given that some individuals find AEs distressing or have existential questions following the experience (Kramer, Bauer, & Hövelmann, 2012), therapists may reasonably expect to encounter clients who are seeking support or who want to explore the significance of the experience. In a survey with mental health professionals in The Netherlands, Eybrechts and Gerding (2012) found that 59% of respondents had been in contact with a client reporting problems associated with spirit contact, 55% with ESP, and 51% with psychic healing. However, 83% had not taken part in any courses about these topics and 35% expressed a need for more training in this area. Likewise, research conducted on the prevalence and phenomenology of SEs, found that 44% of a sample of 226 therapists had experienced SEs in the therapeutic setting, but that these experiences came as a shock to therapists and challenged their concept of reality (author, 2015; author, 2016). Similarly, focus groups with trainee counsellors have revealed that they do not feel equipped to work with clients reporting

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<sup>1</sup> We note that SEs are also sometimes referred to as exceptional human experiences, out of the ordinary experiences, paranormal experiences, or unusual experiences in the literature.

AEs and that they would benefit from learning about the different types of AEs that they could be presented with (authors, submitted).

In Europe, mainly France, Germany, and Holland, specialist counselling services have been set up for the specific purpose of counselling clients who report AEs (see Kramer, Bauer, & Hövelmann, 2012) and some of these have furnished us with information about the different types of AEs that clients seek support for. For example, Belz and Fach (2012) at the Institut für Grenzgebiete der Psychologie und Psychohygiene (IGPP: Institute for Frontier Areas of Psychology and Mental Hygiene) in Germany found 53% of the 1,465 cases recorded to be related to poltergeist and apparition phenomena, 41% to be related to ESP, 38% to be associated with internal presence and influence (e.g., spirit possession), 15% to be associated with external presence and nightmares (e.g., sleep paralysis), 10% to be related to SEs, and 7% to be associated with mediumship.

In terms of supporting individuals who have had AEs, suggestions have been made about specific techniques and approaches that might be beneficial in work with clients, such as mapping a timeline to see if there is a correspondence between emotional life events and when AEs occur or adopting a Rogerian approach (Kramer, 2012), holotropic breathwork and hypnosis (Ahmed, 2012), dreamwork techniques (Kripnner & Friedman, 2010), bibliography (Noble, 1987), psychoeducation, guided imagery and art therapy (Greyson, 1997), group therapy (Parra, 2012), and normalising and demythologising AEs (Bauer et al., 2012; Gerding, 2012). Guidelines have also been published offering advice on how to counsel individuals who have AEs (e.g., Hastings, 1983; Siegel, 1989). For example, Hastings outlines several steps that can be followed: 1) ask the person to describe the experience, 2) listen without judging, 3) reassure the person that they are not 'mad', 4), name the type of AE, 5) provide information about what is known about the AE, 6) develop reality tests to establish whether the AE is genuine, and 7) address the psychological reactions that result

from the AE. Although this would seem to offer some valuable recommendations based on basic counselling skills, psychoeducation, and reality testing, it could be argued that this is too generic, but also that it is not the role of the therapist to establish the authenticity of AEs as in step six (Evrard, 2012; Parra, 2012). It also relies on therapists having knowledge about AE research and theories, in addition to existing counselling skills, so as to provide clients with sufficient information about the process they are going through, and to explain what is known about the phenomenon. Recent research suggests that this might not translate to practice, as when clients have disclosed AEs in mainstream therapeutic contexts, they have reported that they do not feel listened to, accepted or understood (Taylor, 2005), consider the help they receive as inadequate (Eybrechts & Gerding, 2012), fear being ridiculed or pathologised, and are eager to explore the meaning of the experience with an open-minded therapist (authors, in press).

Whilst the growing field of 'clinical parapsychology' is making some progress towards establishing theoretical, research, and clinical material, including case studies, on how to deal with AEs in therapeutic settings (for an overview see Kramer, Bauer, & Hövelmann, 2012), most of these endeavours have come from outside of the UK. There have been no studies, to the authors' knowledge, that have investigated how therapists have worked with clients reporting AEs in UK counselling services. In order to redress this gap in the counselling field, this study aims to explore the experiences of therapists who have worked with such clients to gain an insight into what they think would be useful when addressing AEs, whether they feel competent working with clients reporting AEs, and whether they have received specialist training incorporating AEs. As such, this research acknowledges the need to generate a better understanding of how therapists have worked with clients reporting AEs and whether they have found any approaches helpful or unhelpful so that findings can help inform better therapeutic practice.

## **Method**

### **Design**

A qualitative method was adopted to explore the experiences of therapists who have worked with clients reporting AEs. Thematic analysis was considered appropriate for our research aims as we were interested in whether there are any commonalities in the way therapists work with clients reporting AEs. It is also considered a useful approach 'when you are investigating an under-researched area, or with participants whose views on the topic are not known' (Braun & Clarke, 2006, p. 11). Ethical approval was obtained from the School of Social Sciences Ethics Committee at the authors' university and ethical guidelines of the British Association for Counselling and Psychotherapy (BACP) were adhered to.

### **Participants**

Purposive sampling was used to recruit therapists who had worked with at least one client who had reported an AE. As part of a separate survey study investigating the range and incidence of AEs in a secular counselling setting over a one year period, information about the interview study was distributed to therapists at two charity organisations. We also circulated information about the research to therapists within our network of contacts. Sample size was determined by a number of factors including access to participants, the richness of data, and guidelines for conducting thematic analysis (Braun & Clarke, 2013). Eight therapists took part in the study and consisted of two males and six females. Length of time practising varied between 4 and 27 years ( $M = 12$  years). Their therapeutic orientations included transpersonal, integrative, CBT, hypnotherapy, psychodynamic, and Gestalt (see Table 1). Pseudonyms have been assigned to protect the identity of the participants and any personally identifiable information has been changed or removed to ensure anonymity. Participants were not required to provide any personal details about clients.

## **Data Collection**

Semi-structured interviews were conducted by the second author at a time and place convenient to participants, which included the counselling service where they worked, a university room or their home. Interview questions were open-ended and non-leading and focused on how participants had worked with clients presenting with AEs, for example 'Can you describe the most memorable anomalous experience that was reported by a client?' 'How did it make you feel?', 'What therapeutic approach(es) have you adopted?' 'How have such approaches been beneficial?' 'Have any approaches/techniques been unhelpful?' 'Did the experience affect how you worked with the client?' 'What training did you receive on working with AEs?'. Participants had the option of reviewing the schedule before agreeing to take part in the study, but we highlighted that additional questions may be asked due to the semi-structured nature of the interview format. Duration of interviews varied between 33 and 89 minutes (see Table 1).

Insert Table 1 about here

## **Data Analysis**

An inductive thematic analysis was conducted on the interview data as outlined by Braun and Clarke (2006). In order to maximise validity of themes both authors independently analysed the data and then came together to discuss and refine findings. The first stage in the analytical process consisted of both authors immersing themselves in the data, reading the transcripts several times, and exploring their deeper meaning in terms of the implications for therapists and therapeutic practice. Any interesting observations about the narrative, in relation to the research questions, were noted on the transcripts and initial lists of potential themes were generated. Both authors then reviewed these lists and began a process of clustering themes in order to develop a final table of themes that accurately reflected repeated patterns of meaning

within the data (see Table 2). This data-driven form of analysis together with the semi-structured nature of the interview guide enabled participants to set their own parameters in terms of what they felt important to discuss, which enabled a more thorough understanding of the topic. Short participant extracts were used to name the themes.

### **Reflexive Statement**

Both authors are academics and BACP registered counsellors (with training in integrative approaches) who volunteer for charity organisations. In terms of our own experiences of working with clients who have reported AEs, we note the importance of respecting different explanatory models and to acknowledge the experience as subjectively real for the individual. As we were interested in therapists' experiences and perspectives, we did not aim to establish the veracity of AEs or theorise on the ontology of such experiences, and were mindful in the analysis to be objective and open-minded.

Insert Table 2 about here

### **Findings**

Four key themes were derived from participants' data: 'Testing the waters', 'Exploration not explanation', 'It's special but it's not unique', and 'Forewarned and forearmed'.

#### **'Testing the waters'**

When discussing their experiences of working with clients who had reported AEs, participants naturally drew attention to the client's experience and the manner in which they disclosed AEs. Participants talked about how clients are often hesitant to disclose that they have had an AE for fear that they will be seen as 'mad'. The consequences of this were that clients often 'tested the waters' before sharing details of AEs with therapists. With reference to clients who have sensed the presence of the deceased after bereavement, Charlotte states that they often see how she responds to such issues first before fully divulging the extent of

their experiences, such as maintaining communication with deceased loved ones, or sometimes she can tell that they want to discuss an experience and need a bit of encouragement to do so:

Nearly everybody I see for bereavement, I think, talks to the person they've lost, and some of them will tell you that straight away, others will take a little bit of prompting, because they think it means they're going mad.....I often find that people are quite, sort of tentative, you know, and see how I react to certain things (Charlotte)

Likewise, Diane reflected on how clients are seeking 'permission' that it is okay to talk about AEs in the therapy session without being seen as 'crazy':

Some of them do pre-empt with 'You're gonna think I'm crazy when I tell you this' and they do look for a bit of reassurance, and ask me 'Does that fit with your belief system?' also when mentioning psychics as well...they are saying 'Is this on our agenda? Can we visit this? Can I admit this?' (Diane).

Participants also felt that there was still a lot of stigma attached to mental health issues in general which results in some clients being reluctant to seek support but that perhaps this applied even more so to clients who had AEs. Harriet believed that society's views about 'madness' and AEs becomes entrenched in clients, serving as a barrier to the therapeutic process, and that as a result clients felt that their experiences had to be 'brushed under the carpet':

Often, there's a big link with shame in some of these beliefs as well because I know of clients that actually say that they feel as if they daren't tell people because they'll be stigmatised, because people will think that they're mad or it's not rational or in their line of work they shouldn't be having these kind of

thoughts or ways of being, so they kind of feel as if they have to be brushed under the carpet in some way or deny those aspects of them self. (Harriet)

**'Exploration not explanation'**

In terms of working with clients who report AEs, the majority of participants pointed out that it was important to explore the meaning of the experience from the client's perspective, rather than impose their own interpretation. Harriet mentioned working in the 'here and now' to explore how the client felt about the experience:

Opposed to staying with the, this happened and this is my explanation for it, is the, 'Well let's look at that and explore it. How did you arrive at that?' And I work very much in the here and now as well. So what's coming up for you when you think about that now? And so we can bring it into the session as well. So, say for example, if it was a client that said that they felt, I don't know, they felt that their dead husband was around them, I'd be saying, 'Do you have a sense that he's around you now, then? Tell me what that's like. And how is that helpful to you? When might it be less helpful?' You know, and so we'd work in that way (Harriet)

Charlotte added that she never discusses with clients whether AEs are genuine or not, reiterating that the essential therapeutic process is to explore what the experience means to the client as an individual, in contrast to making a judgement as to what is real or not or imposing one's own explanation:

Some of them want to explore, you know, 'Do I think it is real?' 'What do I think its significance is?' Which, of course, I don't actually ever voice an opinion, and, but I try to find out what it means to them, and then go from there (Charlotte)

Similarly, Sally mentioned that she is interested in hearing the client's personal account and takes the AE at face value regardless of how implausible it may seem:



I accept the story whatever it is, even if it's outlandish even if it rings like totally crazy to me and I try to gauge the capacity of the client. 'So what if this experience is true, what if someone's casting a spell on you, how do you think this is affecting you?', for example, and that's how I kind of try to understand their story (Sally)

Participants also emphasised that exploring the meaning of AEs is no different from how they would normally work. This is exemplified by Harriet and Diane who reflect on the process of therapy being the same for AEs as other issues:

I don't find that working in this way is any different in some ways to working with the client who has experienced horrific, enduring abuse or the client that, I don't know, has an eating disorder, the client that self-harms. Because for me, the process of, is still very similar which is the, as I say, entering the client's world whilst still in your own world and exploring that and looking at it from the client's perspective and then looking at integration or looking at finding places for things, or looking at letting things go, you know (Harriet)

I don't really adopt or use a specific approach except to explore it as I would anything else that they may have brought. To me it's just something else that they've experienced in their very interesting, complex, and complicated lives (Diane)

### **'It's special but it's not unique'**

Participants reflected on how some clients find AEs special in some way, for example, they mentioned how clients who had sensed the presence of the deceased often find the experience therapeutic as it helped with the grieving process, but that at the same time clients also seek reassurance that they are not the only ones having AEs. As Lisa stated:

I think because AEs are anomalous people do get ya know nervous or anxious, they do feel the need for reassurance, clients feel the need for reassurance when they see something that they know is not the norm. There is a need for, 'is this ok?' (Lisa)

They also reflected on how important it was to normalise the experience by letting clients know that other people have had similar experiences. Participants mentioned that this seemed to help ground clients as well as reassure them that it was safe to share their AEs, as Walter and Sally state:

I'm amazed at how much things calm down when you encourage a person to befriend the process and also when you start saying look 'this has happened to other people, it's not about you, this is a, this is like a human experience' (Walter)

As soon as the client understands that whatever they bring I'm not just gonna pass judgement or pass them off as crazy, or suggest they need medication or even 'I can't deal with this', as soon as they get this response they are more equipped to deal with this, that kind of somehow helps them and myself to place the experience back into a more kind of grounded and rationale context (Sally)

Participants also pointed out that in some cultures AEs are not viewed as anomalous and are routinely seen as a normal part of human experience:

I realised in my mental health placement that there seems to be a lot of presence of ethnic minority so when you actually go and speak to clients about the issue of witchcraft it's not mad to them because where they grew up it's very normal and people do cast spells when they hate you so...it has somehow got out of control... but you know what if they find a therapist that knows about it and is capable of putting it back into the right frame whereas rather than say 'Oh my

God that doesn't exist, that is crazy', so a cultural awareness is also very important (Sally)

Within certain cultures, a lot of what we're exploring today would be absolutely embraced, you know, and my guess is that if there were counsellors within certain cultures, they wouldn't be saying, 'Oh no, we can't work with this in six sessions', they'd be, 'bring it in, let's have a look at it' (Harriet)

### **'Forewarned and forearmed'**

Participants felt that it would better prepare therapists to work with clients who report AEs if trainee counsellors/psychotherapists were introduced to the topic early on in their training, emphasising the need for normalisation of AEs not only in society (as per theme 1) and the therapeutic session (as per theme 3) but also 'normalisation within the initial trainings' (Harriet). Graham felt that it would be useful to familiarise therapists with the concept of AEs because 'unless you have some real....erm...faith experience going on it can be rather difficult coz it can be rather daunting if you are faced with anything yourself'. He added that therapists should be aware of their own limits and be prepared to refer clients elsewhere if they felt that AEs were not something they felt comfortable working with:

There is also things going on out there that is in the spiritual realms that if you're not prepared to deal with it then you need to have a very strong sign over your forehead saying 'look I don't do spiritual stuff'... you know take it to someone else down the road coz it frightens the hell out of me (laughs) (Graham)

Charlotte echoed the necessity of referring on but also mentioned that therapists have a responsibility for educating themselves on issues that they are not familiar with:

I think people should be aware, and, I mean, as I say, to me it's no different to anything else that comes up in counselling, that if you don't know enough about it, either go and find out, or if you can't find out or don't feel comfortable

working with it, then you should find, you know, refer them on to somebody who does (Charlotte)

Diane used 'magpie' as a metaphor to represent the assimilative process of therapists continuing their own professional development with further workshops:

We should be a discipline that attends workshops on things that look interesting, the phrase 'magpies' springs to mind. So we go around collecting lots of ideas up and putting them in the bag...I like to think that as a discipline we would magpie this into our own practice in some way (Diane)

### **Discussion**

This study explored therapists experiences of working with clients who had reported AEs. One of the main findings was that participants felt clients had been reluctant to disclose AEs for fear of being seen as 'mad' and so they often 'tested the waters' to see how therapists would respond. Farber (2003) estimated that two-thirds of clients leave something unsaid during therapy sessions and that the most common problems are related to sexual issues, violence, abuse, and feelings of failure. It remains to be seen how common it is for clients to withhold information about AEs but this finding suggests that it might be fruitful to explore this further. Farber adds that there are several factors that affect client disclosure including shame, not wanting to hurt their therapists, considering the issue unimportant, or because the decision to not disclose may be a coping strategy. Participants in the current study believed that client apprehension around disclosure stemmed from stigma attached to mental health issues as well as client fears about how AEs might be interpreted by wider society. This finding corroborates research conducted by the authors that explored clients' experiences of seeking support for AEs, as participants in that study also mentioned testing the waters before sharing details of their experiences as well as a fear of being labelled with a mental disorder if they did (authors, in press).

The findings from both of these studies on AEs draw attention to clients' motives for not seeking counselling and align with the proposition made by Vogel, Wester, and Larsen (2007) that social stigma is one of the most significant factors why individuals may avoid seeking help. Alarming, they cite a study in which 90% of the sample agreed that fear of being seen as 'crazy' was a potential barrier to seeking help. In addition to social stigma, they also argue that treatment fears, fear of emotion, anticipated utility and risk, and self-disclosure are other factors that cause individuals to evade counselling. Interestingly, they propose that different problems may elicit different avoidant responses, for example, treatment fears have been found to be associated with help-seeking for academic problems but not interpersonal or drug problems. Given the wide range of different types of AEs it may be worthwhile if future research investigated whether there are any particular barriers or facilitators associated with seeking support for different types of AEs. One area of exploration that has received relatively little attention in the counselling literature is locus of control in relation to help-seeking behaviour. Applied to the topic of AEs this could, for example, explore whether individuals who report different types of AEs make different attributions about loci of causality, stability, and controllability of their experiences (Weiner, 1974), and in turn if this affects whether they seek support or not. It might be that individuals who claim to experience haunting or alien abduction phenomena, for example, make external attributions (i.e., attribute the phenomena to an outside force or being) and do not seek support because of the anticipated utility and risk factor (i.e., they do not believe that therapy can help with their type of problem or experience).

In terms of the implications for practice, these findings highlight the necessity for therapists and therapeutic services to be active in countering the debilitating effects of stigma. For example, Corrigan and Penn (as cited in Vogel, Wester, & Larson, 2007) argue that this can be achieved in three ways: protest (e.g., therapists should be vocal and draw attention to

negative portrayals of mental health), education (e.g., providing accurate information about mental health), and contact (e.g., reaching out to those experiencing mental health issues or setting up support groups). In terms of AEs specifically, this could be achieved by therapists, services, and training organisations having adequate and reliable information about AEs and the potential link with mental health (Dein, 2012), including research findings and case studies, but also peer-facilitated support groups for AEs, such as those set up by the hearing voice network (HVN) for individuals who hear voices.

In addition, given that participants felt that clients are often seeking permission that it is okay to discuss AEs, therapists could directly ask about these experiences at the assessment stage, not unlike guidelines for working with religious/spiritual issues which suggest taking a spiritual history (see Moreira-Almeida, Koenig, & Lucchetti, 2014). However, further research is necessary to elicit client's reactions to being directly asked about AEs as well as the impact of such experiences on the therapeutic process. With reference to broaching the subjects of race, ethnicity, and culture during the counselling process, Day-Vines et al. (2007) identify a continuum of five different broaching styles that could potentially be applied to raising the subject of AEs: 1) avoidant (issues are rarely discussed or deemed important), 2) isolating (may ask a single question out of feeling obligated to address the subject at least once but the subject remains off-limits as a topic of counselling concern), 3) continuing/incongruent (may consider the subject but has limited skills to fully explore in a way that is empowering for the client), 4) integrated/congruent (therapists broach subjects effectively and have integrated this behaviour into their professional identity, it has become a part of their routine) , and 5) infusing (broaching represents a way of being and a lifestyle choice). Whilst little is known about which style clients might prefer in relation to AEs, we do know that the avoidant and isolating styles would be considered as antithetic to the findings reported here as both clients (authors, in press) and therapists feel it is important to

be able to discuss AEs in therapy. Moreover, findings emphasise that hesitant disclosure or palpable nondisclosure on behalf of the client should be legitimate concerns for the therapist that need to be managed within the dyadic relationship, and that there may be cues in the session that can be picked up which reflect a testing of the water in order to encourage clients to discuss their AEs with less hesitancy.

Another notable finding was that participants felt it was important to explore the meaning of AEs with clients rather than impose an explanation or make a judgement as to the authenticity of such experiences. Again, this validates findings from research with clients who have sought support for AEs (authors, in press) as participants in that study also mentioned the importance of being able to make sense of the experience with an open-minded therapist. It also confirms the view that it is not the therapist's role to establish the reality of AEs (Parra, 2012). Participants also noted that clients sought reassurance that they were not the only ones having AEs and that normalisation often alleviated client's anxieties about this. We acknowledge that normalisation could potentially be problematic, due to the definition of AEs placing these experiences outside of ordinary experience or as deviating from the usually accepted explanations of reality according to Western mainstream science. However, the definition also recognises that AEs may be experienced by a significant number of people and thus normalisation could involve reassuring clients that they are not the only ones to have had such experiences. This would be similar to the guidelines recommended by Hastings (1983) in terms of naming the type of AE and discussing with the client what is known about the AE.

These findings are congruent with studies that have compared clinical and non-clinical samples to investigate predictors of distress associated with AEs, as normalizing and validating contexts in which experiences can be accepted, understood, and shared were shown to be associated with lower distress. Moreover, it has been argued that it is not

necessarily the AE that causes psychological distress but rather individuals' appraisals of the experience as socially and culturally unacceptable (Brett, Heriot-Maitland, McGuire, & Peters, 2013; Heriot-Maitland, Knight, & Peters, 2012).

Participants said that they would work the same way with AEs as they would with any other client issue. This may be reassuring to other therapists, particularly trainees, who have not yet encountered a client reporting an AE or who have wondered how they might work with such issues (authors, submitted). This finding resonates with the common factors model in psychotherapy which argues that therapeutic outcome is related to factors that all approaches share, such as the therapeutic relationship, rather than factors or techniques specific to particular approaches (Cooper, 2008). This is in contrast to recommendations made in clinical guidelines (e.g., by the National Institute for Clinical Excellence) that therapists should use particular approaches with particular types of problems (e.g., CBT for depression) because they have been empirically supported. Given the paucity of research on AEs and therapeutic outcome, in contrast to the wealth of efficacy research on depression and anxiety, further research is needed to explore whether different types of AEs respond to different ways of working.

It is interesting that participants felt that there was a need for the topic of AEs to be introduced to therapists in their training programmes or for workshops to be available, given that they felt they would work with AEs in the same way as other issues. However, the suggestion seemed to stem more from the belief that therapists would benefit from hearing about the different types of AEs and associated research and theoretical material rather than being shown specific techniques for how to work with such experiences, which is a similar finding to research conducted on the training needs of therapists in relation to the issue of working with AEs (authors, submitted). Participants felt that this would better prepare therapists to be aware of their 'comfort zone' but would also help them to be able to



normalise such experiences by being able to reassure clients that others have also reported similar experiences, particularly in the case of clients sensing the presence of the deceased after bereavement, which all but one participant had worked with.

One of the limitations of this research was that only White European therapists came forward to be interviewed. Although some participants reflected on cultural differences with respect to how AEs may be understood, future research could explore the perspectives of a more diverse range of therapists. In addition, the majority of therapists in this sample worked in an integrative or transpersonal way and it may be that therapists from other orientations or professions would have different views about working with clients who report AEs. Indeed different practitioners have varied in terms of their explanations for AEs and how they respond to clients reporting AEs (authors, 2016; Eybrechts & Gerding, 2012). It is speculated that this may be due to differences in training and/or personal beliefs about the nature and causes of such issues, which could have implications for how AEs are addressed. Likewise, it would be useful to know whether specific types of AEs elicit different or similar views in therapists and what impact therapists own experiences of AEs might have on the therapeutic process.

### Conclusion

Participants reflected on how clients are often reluctant to disclose AEs to them for fear of being seen as 'mad'. This validates findings from interviews with clients who have sought support for AEs as participants in that study (authors, in press) also mentioned a fear of being pathologised. In terms of addressing AEs that clients have reported, participants emphasised the importance of exploring the meaning with clients rather than imposing an explanation or making a judgement as to the authenticity of AEs. They also said that they would work the same way with AEs as they would with other issues but that it might be useful for therapists

Running head: 'THEY DAREN'T TELL PEOPLE'

to have reliable and accurate information about AEs and/or for trainees to be introduced to the topic whilst undertaking practitioner training.

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### **Appendix. List of AEs used in the research**

**1. Psychic experiences** are those in which we learn about or influence the world through means other than the conventionally recognised senses (e.g., extrasensory perception/ESP, mind over matter)

**2. Mystical experiences** are those in which there is a strong sense of greater connection, sometimes amounting to union, with the divine, other people, other life forms, objects, surroundings, or the universe itself. Often, this is accompanied by a sense of ecstasy.

**3. Peak experiences** are moments when people experience, more closely than usual, all that one can be. One may feel in the flow of things, self-fulfilled, engaged in optimal functioning, and filled with highest happiness. They may be triggered by art, sport, music, the natural world, tragedy or noble acts.

**4. Out of body experiences (OBEs)** involve a sensation of being outside one's body and, in some cases, perceiving the physical body from a place outside the body.

**5. Hauntings** are characterized by subjective visions ('ghosts') and sometimes noises in a particular location.

**6. Poltergeist activity** is usually associated with a person rather than a place and involves phenomena, such as destruction/relocation of furniture, levitation of cutlery, knocking on doors, unusual noises.

**7. Experiences of unusual healing** include instances of recovery, cure, or enhancement of physical, psychological, or spiritual well-being beyond what is usually experienced or expected on the basis of conventional medical or psychological knowledge (e.g., psychic healing or distant healing).

**8. Encounter experiences** are those in which the person is confronted with something that is actually there but is awesome and wondrous (e.g. a glorious mountain peak) or something that is not supposed to be there (e.g., UFOs, angels, mythical beings, spirit guides).

**9. Reincarnation/past life experiences** include the belief that the soul or spirit has been reborn into another body.

**10. Therianthropy** is the belief that one can transform into an animal and often involves experiencing phantom limbs (feeling as though a body part is missing) or mental shifts (altered state of consciousness).

**11. Synchronicity** is defined as a meaningful connection between an inner event (e.g., thought, vision, dream) and one or more external events occurring at the same time. For example, thinking about someone and that person then phoning you to tell you something important.

**12. Spiritual crisis** often occurs after a spiritual experience or after intense spiritual practice (e.g., meditation, Yoga) and can cause the person to question their beliefs, values, and meaning system.

**13. Alien abduction** involves memories of being taken by apparently nonhuman entities and subjected to physical and/or psychological procedures.

**14. Near death experiences (NDEs)** typically occur to individuals close to death or in dangerous situations and often involve sensations of detachment from the body, feelings of levitation, and the presence of a light.

**15. Unusual death related experiences** include strange experiences associated with the moment of death, such as clocks stopping, mediumship, apparitions of the deceased, feeling a sense of presence, and communication with the deceased.